Missouri Healthcare Information Technology Task Force

Preliminary Report

June 30, 2006

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Task Force Membership

- Julie Eckstein of St. Peters serves as the chairperson for the Healthcare Information Technology Task Force. Ms. Eckstein was appointed Director of the Missouri Department of Health and Senior Services in February 2005 after two decades in community health and healthcare. Ms. Eckstein has a Bachelor of Science degree from the University of Missouri-Columbia and an MBA from Washington University in St. Louis.

- Dan Ross of Jefferson City is the chief information officer for the state of Missouri. Mr. Ross has thirty-seven years in public service, working for the Department of Natural Resources, Missouri State Parks, the Missouri Highway Patrol, the Public Service Commission, and as Executive Deputy Secretary of State to then Secretary of State Matt Blunt. Mr. Ross holds a bachelors degree in Industrial Relations from Lincoln University and a master's degree in Public Administration from the University of Missouri.

- Douglas K. Anning of Kansas City is a shareholder in the Business Law Department at Polsinelli Shalton Welte Suelthaus and vice chair of the Nonprofit Practice Group. Anning's focus is in the areas of general tax and corporate law, nonprofit and tax-exempt organizations and health care organizations. Anning holds a bachelor's degree in philosophy and a juris doctorate from the University of Kansas.

- Gary Duncan of Joplin is president and CEO of Freeman Health System. Duncan is responsible for an integrated health system with three hospitals and a community-based behavioral health unit covering nine counties. Duncan holds a bachelor's degree from Heidelberg College in Ohio and a master's of divinity from Eden Theological Seminary.

- Dr. Karen E. Edison of Columbia is the chairman of the Department of Dermatology at the University of Missouri School of Medicine and medical director for Missouri Telehealth Network. Edison is also the co-director for the Center for Health Policy at the University of Missouri. Edison holds bachelors degrees in biology and English from William Jewell College and a medical degree from the University of Missouri-Columbia.

- Rebecca L. Foudree of Independence is the co-owner of Grain Valley Pharmacy. Foudree's pharmacy offers immunizations for influenza, pneumonia and Hepatitis-B, and is a participant in Missouri's Medicaid disease state management program. Foudree holds a bachelor's degree in pharmacy from the University of Missouri-Kansas City.

- Dr. Joel D. Hassien of Hannibal operates a private practice. Hassien holds a bachelor's degree from Westminster College and a medical degree from the University of Missouri-Columbia.

- Gordon L. Kinne of Springfield is the president of Med Pay. Kinne established Med Pay in 1984 as a third party administrator involved in employee benefit administration. Kinne holds a bachelor's degree from Missouri State University.

- John W. McClellan of Kennett is chief executive officer of Twin Rivers Regional Medical Center. McClellan holds a bachelor's degree in accounting from Transylvania University in Kentucky and a master's of health administration from the University of Kentucky.

- Randy K. Meents, PharmD, of Greenfield is the owner of Greenfield Pharmacy, Inc. He is also a consultant for two long-term care facilities in Dade County. Meents holds a bachelor's degree in pharmacy from Southwestern Oklahoma State University and a doctor of pharmacy degree from Creighton University School of Pharmacy.

- Michael G. Murphy of Chesterfield is the chief executive officer of Mercy Health Plans. Murphy holds a bachelor's degree in pharmacy from St. Louis College of Pharmacy and a master's in business from Washington University.

- Dr. Stephen L. Reintjes of Kansas City is a neurosurgeon at the Kansas City Neurosurgery Group, L.L.C. Reintjes holds a bachelor's degree in philosophy from Georgetown University and a medical degree from the University of Kansas School of Medicine.

- Richard A. Royer of Columbia is the chief executive officer of Primaris. Royer also owns Avalon Development, Inc, a management consulting firm specializing in healthcare. Royer holds a bachelor's degree in accounting from the University of Akron and a master's in business administration from Cleveland State University.

- Dr. Chad P. Shaffer of Kansas City is the chief medical information officer at Truman Medical Centers. Shaffer holds a bachelor's degree in biology and a medical degree from the University of Missouri-Kansas City.

Background

Missouri Healthcare Information Technology Task Force
And the Charge

Governor Matt Blunt signed Executive Order 06-03 on January 17, 2006 establishing a fourteen-member Healthcare Information Technology Task Force. On February 9, 2006 the Governor issued a press release naming the members of the task force. The group consists of two pharmacists, an attorney, three president/CEOs of large health systems, three physicians, a chief medical officer at a major medical center, Missouri state government's chief information officer, a third party benefit administrator, the CEO of a non-profit healthcare consulting firm and the Director for the Missouri Department of Health and Senior Services.

The Governor created the task force to ensure that healthcare information can be readily available to health care providers, consumers and public health agencies in order to make the best healthcare decisions and to improve patient safety by reducing medical errors.

The task force is charged with evaluating and making initial recommendations to the Governor by July 1, 2006 on the following topics:

●Reviewing the current status of healthcare information technology adoption by the healthcare delivery system in Missouri;

●Addressing potential technical, scientific, economic, security, privacy and other issues related to the adoption of interoperable healthcare information technology in Missouri;

●Evaluating the cost of using interoperable healthcare information technology by the healthcare delivery system in Missouri;

●Identifying private resources and public/private partnerships to fund efforts to adopt interoperable healthcare information technology;

●Exploring the use of telemedicine as a vehicle to improve healthcare access to Missourians; and

●Recommending best practices or policies for state government and private entities to promote the adoption of interoperable healthcare information technology by the Missouri healthcare delivery system.

Contents of This Report

Six working groups were formed to examine the topics outlined in the executive order. This report summarizes the efforts to date by the working groups. The Department of Health and Senior Services supplied staff to act as liaisons to assist the working groups. The working groups and chairs are:

1. Current Status, Julie Eckstein
2. Issues, Chad Shaffer
3. Cost Evaluation, Doug Anning
4. Resources, Richard Royer
5. Telemedicine/telehealth, Karen Edison
6. Best Practices, Dan Ross

Methodology

The task force met on March 30, May 11, May 24 and June 29. All meetings were posted in accordance with the Missouri sunshine law. Members of the public were in attendance at the meetings.

A public website aided the communication efforts of the task force members and working group participants. Members of the public were able to view content information and provide comment. The site address is: http://www.dhss.mo.gov/HealthInfoTaskForce/

Visioning

"What does healthcare information technology look like in a perfect world?"

The following concepts defined the task force's vision for healthcare information technology: Partnership focused, uniform data set, variety of access levels, secure, accessible anywhere, "smart card" acts as the access device, data kiosks available at critical access points, biometrics, real-time data, interfaces with existing systems, incentives to enhance adoption efforts, improved patient care, patient-owned, opt-out provisions, the health record would include mental health components and notification reminders for preventative health screenings.

Guiding Principles

The task force adopted a set of guiding principles. The principles consist of five focus areas:

I. Consumer Centered System.

The needs and outcomes for the consumer are the focus of the system. A consumer centered system, rather than provider or vendor centered is favored. The individual patient's needs and the context in which he or she lives (e.g., home life, job, family relationships) can influence the patient's ability to act on the information provided must be considered. Ideally, informed, shared decision making and development of patient knowledge and skills needed for self-management are included.

II. Provider-Driven System

While the system needs to maintain the consumer as the center and focus of the system, healthcare providers will be the primary drivers of the system through the input of information. The system needs to be easy to use for providers and should provide a more efficient environment in which to provide patient care.

III. Utilizing Established Data Standards

A national common framework with sufficiently robust standards will be in place to support and guide participation. The common framework will consist of the essential technical and policy standards necessary to ensure interoperability, serve the patients whose data it shares, and connect systems of varying technical sophistication with accountability and transparency.

IV. A Framework for Connectivity

In order to provide the greatest benefit, clinical applications must connect with other clinical systems. There should be a common framework based on a decentralized network of networks that creates a pathway that facilitates information exchange, with appropriate authorization, in a private and secure way.

V. High Quality, Cost Effective Care

Cost-effective care does not necessarily mean cheap care but, rather, high-value care. Patients receive the right care, at the right time, at the right place and at the right cost. And, they get the best possible results. In addition, providing high-quality care that leads to better functioning outcomes creates benefits for many other parties not involved in health care. For instance, benefits accrue to the employers of better-treated patients through reduced absenteeism and higher productivity, to family members and friends through lower burdens of care for sick people, and to government agencies through fewer transfer payments (welfare, unemployment, and disability).

Presentations

Presentations were conducted to educate the members of the task force about a variety of healthcare information technology issues. Presentations were offered from:

Dr. Karen Edison, Medical Director, Missouri Telehealth Network

Browsersoft is currently working on one of the four contracts from the Department of Health and Human Services to develop a prototype for the National Health Information Network. Additionally, Browsersoft has completed a pilot project in Mendocino County, California to exchange health records between multiple facilities.

Citizens Memorial Hospital has implemented an electronic health system that is shared between two separate organizations that includes patient visits across the continuum of care. The capabilities of their system include the ability to share data with certain area physicians.

Cerner Corporation discussed approaches for building a data exchange and highlighting their work with Healthe Mid-America in Kansas City, an employer led health data exchange initiative.

Blue Cross Blue Shield of Missouri presented Missouri's Claims Record for the Emergency Department Pilot Project. This project focuses on providing emergency departments with access to a patient's claims data. This project is part of a nationwide effort by Blue Cross Blue Shield and has been integrated with Personal Health Records in other states.

BJC HealthCare presented MyHealthFolders.com, a secure and confidential health information repository.

Working Group Reports

Current Status Working Group

PARTICIPANT NAME	ORGANIZATION / REPRESENTING
Julie Eckstein	Task Force Chair Working Group Chair
Rebecca Foudree	Task Force Member
Dan Ross	Task Force Member
Ken Kuebler	Missouri Hospital Association
John Wade	VP/CIO for Saint Luke's Health System Most Wired Health System Award Winner
Teresa Knox	Manager, Health Info Management, St. John's Health System. Mo Health Information Management Association
Jeffrey Kerr	Missouri Association of Osteopathic Physicians and Surgeons; Board of Senior Services member
Andrew Johnson	Primaris
Pam Victor	Missouri Association of Health Plans
Gordon Wong	Blue Cross/Blue Shield – Wellpoint
Mr. Pat Mills	Missouri State Medical Association
Patrick Baker or Jon Dolan	Missouri Healthcare Association
Kerri Hock and Cathy Thompson	Missouri Assisted Living Association
Betsy Stevens	Missouri Association of Nursing Home Administrators
Justin Copeland and Kim Arnold	Missouri Primary Care Association
Wilbert Meyer	Missouri Rural Health Association
Mahree Skala	Missouri Association of Local Public Health Agencies
Jacob Lippert	Missouri Dental Association
Cory Ridenhour and Joyce Baker	Missouri Optometry Association
Belinda Heimericks	Missouri Nurses Association
Clive Woodward	Department of Mental Health
Dr. George Oestreich	Department of Social Services, Division of Medical Services
Bill Whitmar	Health laboratories

Goals/Objective: Assess the current status of healthcare information technology as it relates to the development of Regional Health Information Organizations (RHIO) and Health Information Exchanges (HIE) within Missouri, as well as the status of adoption of healthcare information technology by health care providers, including physicians offices, health plans local public health agencies, long-term care facilities and pharmacies.

Two members of the task force conducted a public meeting on May 3, 2006 to determine a work plan and identify potential participants for the working group. Three public meetings via conference call were held on May 11, May 23 and June 20, 2006. The working group developed

a survey, appropriate for state-wide distribution, to assist in understanding the current status of healthcare information technology availability, utilization and efficacy within our state. The survey took approximately ten minutes to complete. The survey was deployed on May 26, 2006. The survey period concluded on June 9, 2006. The survey consisted of six sections:

Profile – used to gain an understanding of the type and size of healthcare organization, the position within the facility, the facility gross revenue and contact information.

Level of Adoption – used to assess the current level of adoption within a facility and the barriers to adoption.

Areas of Implementation – used to determine the components of the electronic health system, whether the system was built or purchased, the system's owner, the length of time the system had been utilized, and whether implementation was planned.

Cost – this category defined how the electronic health system was purchased, the total cost of the system, on-going annual costs, estimated savings to the organization through the use of the system, types of savings the organization hopes to achieve from utilization and the estimated return on investment.

Information Exchange – this category was used to identify the level of information exchange the organization was involved in, the types of data sharing repositories currently utilized and any Regional Health Information Organizations (RHIOs) or Health Information Exchanges (HIEs) the organization is involved with.

Satisfaction – this optional section was used to assess overall satisfaction with electronic health records and telehealth systems, whether the individual would recommend the system, whether the system was a worthwhile investment, satisfaction rates related to improved patient safety, ability to reduce duplicative procedures, ability to reduce medical errors, improved coordination of care with other providers, improved coordination with patients, improved coordination with payers, improved coordination with hospitals/ancillary sites, whether adopted enhanced HIPAA compliance, improved access to healthcare for the patient, improved efficiency and improved public health monitoring capabilities.

Results were compiled from 790 surveys. Data analysis is currently underway by the Department of Health and Senior Services, Bureau of Health Informatics. A final meeting will be held to reach consensus on conclusions about the survey with the working group participants. The conclusions will be provided to the task force members to inform recommendations presented in the September 1, 2006 report.

Issues Working Group

Current Status Working Group Participants:

PARTICIPANT NAME	ORGANIZATION / REPRESENTING
Chad Shaffer	Task Force Member Working Group Chair
Dr. Karen Edison	Task Force Member Working Group Vice-Chair
Dr. Joel Hassien	Task Force Member
Doug K. Anning	Task Force Member
Michelle Kornfeld	Missouri Health Information Management Association
Tony Krawat	St. John's Mercy Health
Rebecca Miller	Missouri Center for Patient Safety
Larry Musbach	Quick Study Radiology
K. Jody Smith and Julie Wolter	St. Louis University, Department of Health and Information Management
John Daniel	Gridlox, Inc.
Steven E. Waldren	Center for Health Information Technology
Skip Martin	SynApps Software

Goals/Objective: Review the current state of potential technical, scientific, economic, security, privacy and other issues related to the adoption of interoperable review healthcare information technology. Identify ideal state for potential technical, scientific, economic, security, privacy and other issues for a successful adoption of interoperable healthcare. Identify barriers and solutions in obtaining ideal state information technology. Identify short term and long term future state recommendations relative to technical, scientific, economic, security, privacy and other issues related to the adoption of interoperable healthcare information technology.

Three public meetings via teleconference and WebEx online meetings were held on May 26, June 2, and June 12, 2006. This online tool enabled the participants to review, discuss, and create a working document in a much shorter amount of time from remote locations. An initial work plan and potential participants were identified by the chair prior to the first meeting. The work plan and participants were finalized during the first meeting. Significant amounts of material were reviewed by participants of the group between the meetings. Materials were posted on the public communication website for review. Group discussion led to a high level summary document. The following outline represents issues that have been identified by this working group:

1. Follow the Guiding Principles
    a. Consumer Centered System
    b. Provider Driven System
    c. Utilizing Established Data Standards
    d. Framework for Connectivity
    e. High Quality-Cost Effective Care

2. General philosophy-Grass Roots vs. Top Down
    a. Grass Roots-organization that provides resources, education, but does not provide direction or make decisions.
    b. Top Down-State sponsored or State run initiative that mandates or drives activities.

3. Create clear, achievable, and measurable goals

4. Health Records
    a. Provider centered
        i. Provide integrated clinical data at the point of care
        ii. Information integrated to workflow
        iii. Easy to use
        iv. Clinical decision support
    b. Consumer centered
        i. Provide consumers with meaningful information to assist them in making informed healthcare decisions
        ii. Ensure health information security and privacy is protected
        iii. Ensure that consumers retain the rights of access to their health information

5. Cost effective
    a. Integrate with existing systems
    b. Cost should not exceed the perceived benefits to all stakeholders
        i. Short term-initial implementation costs
        ii. Long term-ongoing sustainability

6. Adoption issues
    a. Consumer/provider buy-in and education
    b. Need to have an incentive level for the major providers and C-level
    c. Payor quality metrics
    d. Need to develop motivators for the providers on an individual basis
    e. Healthcare provider Champion to lead the adoption process
        i. Regional efforts
        ii. Centralized State coordination
        iii. Aligned with Federal efforts

7. Organizational structure and model
    a. Governance
        i. Internal
            1. Committee structure
            2. Strategic planning
            3. Oversight
        ii. Participants
            1. Providers

2. Payors
3. Consumers

b. Technical
    i. Centralized data warehouse-all data is in one common database
    ii. Federated models-data stays in-house and pull as needed
    iii. Portable first, then interoperable
c. Funding mechanism
    i. Short term
    ii. Long term and sustainability
d. Mechanisms for interoperating beyond our state borders

8. Multiple points of entry
    a. Access for those who are not technically capable
    b. Availability of technology for users
    c. What are "successful" adoption rates?

9. Multiple record types
    a. Clinical record
    b. Personal health record
    c. Financial record

10. Flexible privacy and security model
    a. Conforming to governing laws and regulations
        i. HIPAA compliance
        ii. State law and regulations
        iii. Accrediting bodies
        iv. Institutional/provider bylaws and regulations
    b. Patient specified access
    c. Degree of granularity
        i. Summary
        ii. Partial record
        iii. Complete record
    d. Accommodates emergency access

The working group will continue to meet to explore these issues in detail so that proposed recommendations can be provided to the task force.

Cost Evaluation Working Group

PARTICIPANT NAME	ORGANIZATION/REPRESENTING
Doug Anning	Task Force Member Working Group Chair
Gordon Kinne	Task Force Member
Randy Meents	Task Force Member
Dr. Steve Reintjes	Task Force Member
Matt Niewald	Dentist
Patrick Boyle	IBM
Craig Johnston	Zak Companies
Keith Olenik	Olenik Consulting Group
John Wade	VP/CIO for St. Luke's Health System
Tom Pagano	Truman Medical Center
David Weiss	BJC

Goals/Objective: Evaluate the cost of using interoperable healthcare information technology by the healthcare delivery system in Missouri. In addition to determining costs, explore the benefits of healthcare information technology adoption to weigh the costs and benefits of adoption and, if possible, determine a return on investment for healthcare information technology dollars invested. In determining benefits, the working group will consider both hard or quantitative benefits, such as health care dollars saved, as well as soft or qualitative benefits, such as improved quality of care and improved public health.

The working group met by teleconference on June 7, 2006. The next meeting is July 11, 2006. It will continue to meet monthly by teleconference on the 2nd Tuesday of each month at 8 am, and more frequently as needed.

Scope: The scope of healthcare information technology adoption in Missouri will affect factors such as the cost of healthcare information technology adoption and the benefits derived from. Accordingly, no clear conclusions about costs and benefits of healthcare information technology adoption can be made until certain assumptions about the scope of healthcare information technology adoption are made. For example, the cost of implementing a consumer/patient-driven personal health record across the state may be relatively small, but benefits might be slight as well. Conversely, implementing a state wide RHIO that has multiple platforms (community health records, e-prescribing, real time laboratory and radiology reports, bio-surveillance and pandemic monitoring, immunization monitoring, chronic disease monitoring, and clinical capabilities) would be significantly more expensive to implement yet could yield significantly more benefit. The issue of scope presents itself in a number of areas, all affecting the cost/benefit analysis:

- Geography: The cost/benefit analysis will vary based on the geographic scope of adoption. Costs and benefits would be affected if healthcare information technology adoption occurred only in the large metropolitan areas versus a truly state wide adoption.
- Services: The cost/benefit analysis will vary depending on the scope of services implemented. As pointed out above, costs and benefits would be affected if healthcare information technology adoption only included the creation of personal health records versus including a wide array of service platforms such as the ones discussed above.
- Technology: The cost/benefit analysis will vary depending on the scope of technology employed. Costs and benefits would be affected if healthcare information technology adoption required each clinical provider to incur significant costs in order to acquire special hardware and/or software versus a system that was accessible through a secure web portal where any provide with internet access would automatically have all the hardware and software they need without incurring the additional cost to obtain specialized equipment and programs.

The scope of healthcare information technology adoption affects any cost/benefit evaluation. Without making an assumption about the scope of adoption, a cost/benefit evaluation cannot occur. Unfortunately, any assumptions the working group makes about scope will be purely arbitrary and may not reflect what eventually is adopted statewide, making any cost/benefit evaluation based on that assumption irrelevant if the assumed scope of adoption does not match the actual scope of adoption.

Availability of Data Resources: An independent and comprehensive cost/benefit analysis would take more time and resources than the working group, or the task force itself for that matter, has at its disposal. Further, there is no sense in recreating the wheel. Accordingly, the working group will look to external sources regarding cost/benefit analysis with respect to healthcare information technology adoption. One of the problems, however, is that because the healthcare information technology industry is in such a nascent stage, few resources exist, and those that do admit that they are highly speculative.

During the month of July, the working group will look at some of these external resources and attempt to adapt them for use in making cost/benefit conclusions about healthcare information technology adoption in Missouri. In August, the working group will assimilate the various sources of data to identify proposed recommendations.

Resources Working Group

PARTICIPANT NAME	ORGANIZATION/REPRESENTING
Rick Royer	Primaris Task Force Member Working Group Chair
Michael Murphy	Task Force Member
Becky Miller	Primaris
John Wade	St. Luke's Hospital
Bull Bruning	MidAmerica Coalition on Healthcare

Goals/Objective: To identify and evaluate potential sources of funding or financing a system (or systems) of interactive Information Technology connecting healthcare stakeholders throughout the state.

The working group met on June 21, 2006 and plans to continue to meet as necessary.

Tasks currently underway include the examination of different funding models (subscription, consumer fees, etc.) to be used for ongoing support. Discussions are in progress about different options on system architecture and their impact on funding. The group has identified key initiatives in financing strategies that have shown promise in other states. And finally, the group is reviewing the mechanism of a "public-utility model" for ongoing governance of the system.

Identification of costs & design will be required before the group is able to conclude its work. All group participants have individual assignments relating to the tasks underway. The group anticipates formulating recommendations for task force consideration within the next month.

Telemedicine/Telehealth Working Group

Telemedicine/Telehealth Working Group Participants

PARTICIPANT NAME	ORGANIZATION
Karen Edison, MD	Task Force Member Working Group Chair
Randy Meents, PharmD	Task Force Member
Joel Hassien, MD	Task Force Member
Deborah Beezley	Director, Health Information Management St. Anthony's Medical Center
Dick Dillon	Telemedicine and Mental Health, Preferred Family Healthcare
Cheryl Fitch and Karen Thomas	Oxford Healthcare
Jill Harrelson	Children's Mercy Hospital
Steven Kropp	St. Luke's Health System
Rachel Mutrux	Missouri Telehealth Network
Jody Smith, PhD	St. Louis University
Stuart Charles Sweet, MD	St. Louis Children's Hospital
Weldon Webb	University of Missouri School of Medicine Director of Rural Programs

Participants of the Telemedicine Working Group are of diverse backgrounds and bring considerable experience to the project. We are a geographically diverse group and have expertise in the clinical, operational, and technical aspects of telemedicine and telehealth from a variety of programs across Missouri.

Goals/Objectives: Catalogue current ongoing telemedicine and telehealth activity in Missouri, learn about best practices in other states and provide concrete suggestions for using telemedicine to increase access for Missourians.

A Preliminary Working Group meeting was held on June 19, 2006. By July 30, 2006, all working group participants to provide input from their specialty or region about ongoing telehealth activity in Missouri. All working group participants will have gathered examples of best practices in other states – programs using telehealth to increase access to, increase quality of, and decrease the cost of health care.

A second working group meeting is scheduled for July 17th at 3pm in Columbia to discuss findings and proposed recommendations.

Best Practices Working Group

Best Practices Working Group Participants:

PARTICIPANT NAME	ORGANIZATION
Dan Ross	Task Force Member Working Group Chair
John McClellan	Task Force Member
Dr. Chad Shaffer	Task Force Member
Gordon Kinne	Task Force Member
Gary Duncan	Task Force Member
Michael Murphy	Task Force Member
Dr. Shawn Griffin	Heartland Health
Dr. George Oestreich	Missouri Department of Social Services
Stacie Durkin	Durkin and Associates

Goals/Objective: To research and recommend best practices or policies for state government and private entities to promote the adoption of interoperable healthcare information technology by the Missouri healthcare delivery system.

Due to busy schedules and travel limitations to Jefferson City, meetings were conducted via conference calls. Conference calls were held on June 6, 20006 and June 13, 2006. A number of articles relative to best practices were shared with participants using the public healthcare information technology communication website.

A variety of issues influence best practices. Those include:

- Laws differ from state-to-state regarding the release of medical record information, complicating the acquisition of data from other states and the business rules for standardizing health record data elements. Federal laws for release and exchange of electronic healthcare records, (e.g. HIPAA), can be trumped by existing state laws.

- Electronic healthcare records may be difficult for small entities to implement due to a lack of knowledge and funds for technology expenditures.

- Many standards already exist such as the Uniform Billing Standards and the HIPAA data transaction record standards, and the Systemized Nomenclature of Medicine Clinical Terms (SNOMED CT). Several electronic healthcare data standards are in the development stage by both government and private entities.

- The challenges to shared electronic healthcare records are not so much related to technology issues, but rather organizational and policy issues.

- Ideally, there will be a need for a unique patient identification number so that multiple records from multiple locations can be verified as belonging to the same patient. In the absence of a singular identifier, several different types of patient identifiers may be needed for probabilistic matching.

- Some states are already sharing patient prescription data across health providers, practitioners and health plans. However, a complete record of prescriptions is challenging because patients may not give each provider the same information. Also, drug samples are often provided to the patient without documentation of a pharmacy record.

The Best Practices Working Group intends to present the following recommendations for the consideration to the task force:

- Align incentives with data provider needs.

- Design a system that will allow for direct input and access for providers.

- Form a steering committee to continue beyond the Missouri Healthcare Information Technology Task Force and allocate resources to the committees.

- Create a governance structure that will ensure the implementation and maintenance of a shared electronic healthcare record system.

- Recruit more subject matter experts to serve on related task forces and committees.

- Leverage the outcomes and knowledge of the Missouri Healthcare Information Technology Task Force for future initiatives.

- Create a business model that will address both short-term and long-term sustainability of an electronic healthcare record system.

Conclusion

Reports from the Institute of Medicine (IOM – 2002, 2004) and other national studies provide clear evidence that health information technology, such as electronic health records (EHR), e-prescribing, and personal health records, plays a critical role in delivering the information needed to address the challenges our healthcare system faces. Healthcare information technology is being adopted in Missouri in both independent and interdependent systems. While we are encouraged by the activity and investment and what that can mean for Missouri healthcare consumers, there remains the obvious concern of high-level coordination to ensure interoperability between the diverse realm of systems. Ensuring interoperability for these tools will help improve the quality, safety, and efficiency of Missouri and our nation's health and healthcare system with potentially significant annual cost savings. The task force applauds you for recognizing the promise that electronic connectivity holds.

Much work has been done, but much remains. The next steps include a task-force wide review of all working group reports. Through the exchange of ideas, expertise and information research, the task force will review the findings and proposed recommendations from the six working groups.

On behalf of the entire Missouri Healthcare Information Technology Task Force, we look forward to providing you with a final report by September 1, 2006.